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Editorial

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Chronic Pain Epidemic

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Editorial

The International Association for the Study of Pain (IASP) defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage" **[1].** When pain is of short duration, it is generally classified as acute, while chronic pain is often considered to be pain that has persisted beyond the normal tissue healing time, usually taken to be 3 or 6 months **[1].** Most patients with acute pain can be managed by self-care or primary care providers, those with chronic pain face greater challenges. Since pain is often viewed as a symptom, pain treatment is offered by professionals from different backgrounds instead of providing the comprehensive multidisciplinary pain care that many patients need. Most patients with severe chronic pain are never referred to a pain specialist or are referred only after lengthy delay. In addition, patients who are referred for care by pain specialists often face difficulties with access.

Chronic pain was recently recognized by the World Health Organization (WHO) as a disease, resulting in revisions to the latest (11th) version of the International Classification of Diseases (ICD-11) **[2].** According to several large population-based surveys, an estimated one in five Canadians lives with chronic pain **[3-5].** Two thirds of Canadians living with chronic pain report their pain is moderate (52%) to severe (14%), and 50% have lived with chronic pain for over ten years **[3].** On average it took 3 years of pain symptoms before first consultation with General Practitioner and the median time from the first pain sensations until the appointment in a Specialized Pain Center was 12 years **[6].** Chronic pain carries both human and economic costs for families, communities, and society. In addition to the direct health care costs, pain undermines one's ability to participate fully in relationships, schools, workplaces, and communities. While there are less robust data in Canada, in the United States, the total annual cost of chronic pain including both direct healthcare costs and costs related to lost productivity were estimated to be $560

billion [7]. Taking these estimates and applying them to the Canadian population, the estimated combined direct and indirect costs of chronic pain in Canada would total approximately $56 to $60 billion per year [8]. Chronic pain is one of the most common reasons for seeking health care in both Canada and the United States [2,9,10].

Pain is the most common reason people seek health care and the leading cause of disability in the world. Many Canadians do not have access to a range of adequate or appropriate pain management services. This can lead to inadequate treatment in the early stages of a condition and exacerbate problems over time. People must also navigate across multiple systems for reimbursement of services, including the public system, private insurance, and out-of-pocket, therefore access can largely depend on the type of insurance and how much money an individual has for services – a concern for those with low-income or without private health insurance. The median economic burden was $1,462 dollars per month, with 95% of these costs being borne by the individual [11]. Many patients feels that the present health care system in Canada fails those who need pain care. Undertreatment and disparities in care have been repeatedly demonstrated. Anxiety and fear around opioids have also led to unmanaged pain. It is imperative that the existing pain care providers and organizations work together under a pain medicine umbrella to improve the safety and quality of pain care, improve the safety and quality of life for patients in pain, and reduce the burden of chronic pain as a major public health problem in Canada.

In Canada, optimal chronic pain treatment is a big challenge for patients [12] and their care providers who are often not fully equipped to manage this condition [13,14]. There are significant gaps in pain education of health professionals. The pain education in Canada remains inadequate across disciplines, with significant knowledge gaps in both pre- and post-licensure contexts [14-16]. Despite recent efforts to improve the medical curriculum, a recent report from the Canadian Pain Task force highlighted significant knowledge gaps in pain prevention and treatment practices before and after licensure [13]. This knowledge gap is surprising given that one in five individuals live with chronic pain, and this condition costs between 38.3 and 40.4 billion dollars in direct and indirect health care costs per year [17].

The literature showed that the existing pain care in Canada is fragmented, inconsistent, and incomplete, with uneven access and disparate quality. There is evidence that indicating multidisciplinary pain clinics are clinically and economically effective, making up an important part of the spectrum of pain care [18]. Treatment might involve a multidisciplinary approach whereby patients work with multiple health professionals separately to establish care plans or might include interdisciplinary services involving highly integrated teams working together to establish a single patient-centred pain management plan. In its 2019 report, the Canadian Pain Task Force concluded that pharmacological treatments are most effective when combined with physical, psychological, and self-management techniques within an integrated multidisciplinary pain management plan [13]. Multidisciplinary Pain Treatment Facilities (MPTFs) exist within tiered pain management networks to provide integrated multimodal care for people living with chronic pain [19]. It also provides interventional procedures, education, training, research, and support to those who provide care in community or primary care settings. Research in 2005-2006 found that the median wait time for a first consultation in a Canadian public MPTF was 6 months and could be as long as 5 years [20]. The same study also found that wait time for public MPTFs is approximately 12 times longer than that of non-public

MPTFs. Research demonstrates these care models lead to a decreases in pain intensity, as well as the fear, stress, depression, and anxiety that often accompany chronic pain. Multidisciplinary clinics have also been associated with a decrease in the use of medication, health care utilization, and disability claims while increasing activity and functioning and self-efficacy, which can subsequently result in cost savings for the health system **[21-25].**

The Canadian Pain Task Force was established in March 2019 to help the Government of Canada better understand and address the needs of Canadians who live with pain. In the first phase, the Task Force assessed how chronic pain is currently addressed in Canada **[13].** In the second phase, the Task Force identified best practices and an improved approach to care, education and awareness, research and related infrastructure, and health system monitoring **[17].** In March 2021, the Task Force submitted an Action plan for pain in Canada to provide recommendations on priority actions to ensure that people with pain are recognized and supported, and that pain is managed effectively across Canada **[26].**

There is an urgent need to address pain in Canada. Stakeholders have expressed the key priorities of a national strategy and several provinces are leading efforts to better coordinate and support optimal chronic pain management within their authorities. There is a need to put these recommendations into action. All stakeholders must join hands for positive and lasting change. Together, we must work together to ensure that the pain is managed effectively across Canada.

References

1. Merskey H, Bogduk N. Classification of Chronic Pain. 2nd Edition, IASP Task Force on Taxonomy. IASP Press, Seattle. 1994.
2. Institute of Medicine (US) Committee on Advancing Pain Research, Care, and Education. Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research. Washington (DC): National Academies Press (US); 2011;3, Care of People with Pain.
3. Schopflocher D, Taenzer P, Jovey R. The prevalence of chronic pain in Canada. Pain Res Manag. 2011;16(6):445-50.
4. Reitsma ML, Tranmer JE, Buchanan DM, Vandenkerkhof EG. The prevalence of chronic pain and pain-related interference in the Canadian population from 1994 to 2008. Chronic Dis Inj Can. 2011;31(4):157-64.
5. Steingrimsdottir ÓA, Landmark T, Macfarlane GJ, Nielsen CS. Defining chronic pain in epidemiological studies: a systematic review and meta-analysis. Pain. 2017;158(11):2092-107.
6. Schulte E, Hermann K, Berghöfer A, et al. Referral practices in patients suffering from non-malignant chronic pain. Eur J Pain. 2010;14(3):308.e1-308.e10.
7. Gaskin DJ, Richard P, Walburn J. The economical impact of pain. Neuroimag Pain. 2017;1-17.
8. Wilson MG, Lavis JN, Ellen ME. Supporting chronic pain management across provincial and territorial health systems in Canada: Findings from two stakeholder dialogues. Pain Res Manag. 2015;20(5):269-79.
9. Finley CR, Chan DS, Garrison S, Korownyk C, Kolber MR, Campbell S. What are the most common conditions in primary care? Systematic review. Can Fam Physician. 2018;64(11):832-40.

10. Todd KH, Cowan P, Kelly N, Homel P. Chronic or recurrent pain in the emergency department: national telephone survey of patient experience. West J Emerg Med. 2010;11(5):408-15.
11. Guerriere DN, Choiniere M, Dion D, Peng P, Stafford-Coyte E, Zagorski B, et al. The Canadian STOP-PAIN project - part 2: What is the cost of pain for patients on waitlists of multidisciplinary pain treatment facilities? Can J Anaesth. 2010;57(6):549-58.
12. Choiniere M, Dion D, Peng P, et al. The Canadian STOP-PAIN project -Part 1: who are the patients on the waitlists of multidisciplinary pain treatment facilities? Can J Anaesth. 2010;57:539-48.
13. Campbell F, Hudspith M, Anderson M, et al. Chronic pain in Canada: laying a foundation for action: a report of the Canadian pain Task force. Ottawa, ON: Health Canada, 2019.
14. Watt-Watson J, McGillion M, Hunter J, Choinière M, Clark AJ, Dewar A, et al. A survey of prelicensure pain curricula in health science faculties in Canadian universities. Pain Res Manag. 2009;14(6):439-44.
15. National Academies of Sciences, Engineering, and Medicine (NASEM). The role of nonpharmacological approaches to pain management: Proceedings of a workshop. The National Academies Press. 2019.
16. Thompson K, Johnson MI, Milligan J, Briggs M. Twenty-five years of pain education research-what have we learned? Findings from a comprehensive scoping review of research into pre-registration pain education for health professionals. Pain. 2018;159(11):2146-58.
17. Campbell F, Hudspith M, Choinière M, et al. Working Together to Better Understand, Prevent, and Manage Chronic Pain: What We Heard. 2020.
18. Tunks ER, Weir R, Crook J. Epidemiologic perspective on chronic pain treatment. Can J Psychiatry. 2008;53(4):235-42.
19. Choiniere M, Peng P, Gilron I, et al. Accessing care in multidisciplinary pain treatment facilities continues to be a challenge in Canada. Reg Anesth Pain Med. 2020;45(12):943-8.
20. Peng P, Choiniere M, Dion D, et al. Challenges in accessing multidisciplinary pain treatment facilities in Canada. Can J Anaesth. 2007;54(12):977-84.
21. Katz L, Patterson L, Zacharias R. Evaluation of an interdisciplinary chronic pain program and predictors of readiness for change. Can J Pain. 2019;3(1):70-78.
22. Chou R, Deyo R, Devine B, Hansen R, Sullivan S, Jarvik JG, et al. The effectiveness and risks of long-term opioid treatment of chronic pain. Ann Intern Med. 2015;162(4):276-86.
23. Waddell K, Moat K, Lavis J. Evidence briefs: Developing a national pain strategy for Canada. (Evidence Brief). Hamilton, Canada: McMaster Health Forum. 2017b.
24. Canadian Agency for Drugs and Technologies in Health (CADTH). Access to and availability of non-pharmacological treatments for chronic non-cancer pain in Canada: An environmental scan. (Report). CADTH. 2018d.
25. Canadian Agency for Drugs and Technologies in Health (CADTH). Multidisciplinary treatment programs for patients with chronic non-malignant pain: A review of clinical effectiveness, cost-effectiveness, and guidelines – an update. (Summary). CADTH. 2019c.
26. An Action Plan for Pain in Canada. 2021.

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